FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039305

Facility Name: Linden Estate

Address: 1000 Linden (Number) Morton (City) 61550 (Zip Code)

County: Tazewell

Telephone Number: (309) 266-9781 **Fax #** (309) 266-9468

IDPA ID Number: 23-7033585-004

Date of Initial License for Current Owners: 09/17/1994

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Matthew D. Steffen **Telephone Number:** (309) 266-9781

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 06/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Helen Schuon
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	16	Intermediate/DD	16	5,856	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,379			5,379	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,379			5,379	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.85%

D. How many bed-hold days during this year were paid by Public Aid?
186 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	26,111	2,535	1,329	29,975	(14)	29,961	0	29,961			1
2	Food Purchase		26,241		26,241		26,241	0	26,241			2
3	Housekeeping		1,944		1,944		1,944	0	1,944			3
4	Laundry		926		926		926	0	926			4
5	Heat and Other Utilities			17,496	17,496		17,496	0	17,496			5
6	Maintenance	14,370	1,814	3,779	19,963	(402)	19,561	(388)	19,173			6
7	Other (specify):*				0		0	0	0			7
8	**TOTAL General Services**	40,481	33,460	22,604	96,545	(416)	96,129	(388)	95,741			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	19,229	5,698	746	25,673	(1,496)	24,177	0	24,177			10
10a	Therapy	201,320		1,574	202,894	(60)	202,834	0	202,834			10a
11	Activities		1,433		1,433	233	1,666	0	1,666			11
12	Social Services	32,693	6	2,513	35,212	(1,134)	34,078	0	34,078			12
13	Nurse Aide Training		68		68	2,741	2,809	0	2,809			13
14	Program Transportation		2,931		2,931	(2,931)	0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	253,242	10,136	4,833	268,211	(2,647)	265,564	0	265,564			16
	C. General Administration											
17	Administrative	16,035			16,035	(18)	16,017	0	16,017			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			3,115	3,115		3,115	0	3,115			19
20	Dues, Fees, Subscriptions & Promotions			3,145	3,145		3,145	(143)	3,002			20
21	Clerical & General Office Expenses	29,386	2,686		32,072		32,072	0	32,072			21
22	Employee Benefits & Payroll Taxes			112,588	112,588		112,588	0	112,588			22
23	Inservice Training & Education			503	503		503	0	503			23
24	Travel and Seminar			317	317		317	(224)	93			24
25	Other Admin. Staff Transportation			230	230		230	0	230			25
26	Insurance-Prop.Liab.Malpractice			7,080	7,080		7,080	0	7,080			26
27	Other (specify):*			3,334	3,334	(3,342)	(8)	0	(8)			27
28	**TOTAL General Administration**	45,421	2,686	130,312	178,419	(3,360)	175,059	(367)	174,692			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	339,144	46,282	157,749	543,175	(6,423)	536,752	(755)	535,997			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Linden Estate #0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,944	30,944		30,944	0	30,944			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds			2,520	2,520		2,520	0	2,520			34
35	Rent-Equipment & Vehicles				0		0	0	0			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			33,464	33,464	0	33,464	0	33,464			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0	3,319	3,319	(3,319)	0			38
39	Ancillary Service Centers				0	3,103	3,103	0	3,103			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			34,164	34,164		34,164	0	34,164			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	34,164	34,164	6,422	40,586	(3,319)	37,267			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	339,144	46,282	225,377	610,803	(1)	610,802	(4,074)	606,728			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(143)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,931)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,074)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 0		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (4,074)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Linden Estate

ID# 0039305

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset day draining transportation income	$ (3,319)	38	1
2	Offset day draining transportation income	(388)	6	2
3	Out of State Travel (Board of Directors)	(224)	24	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27

28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,931)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(388)	0	0	0	0	0	0	0	0	0	0	(388)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(388)	0	0	0	0	0	0	0	0	0	0	(388)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(143)	0	0	0	0	0	0	0	0	0	0	(143)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(224)	0	0	0	0	0	0	0	0	0	0	(224)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(367)	0	0	0	0	0	0	0	0	0	0	(367)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(755)	0	0	0	0	0	0	0	0	0	0	(755)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Linden Estate # 0039305 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(3,319)	0	0	0	0	0	0	0	0	0	0	(3,319)	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(3,319)	0	0	0	0	0	0	0	0	0	0	(3,319)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,074)	0	0	0	0	0	0	0	0	0	0	(4,074)	45

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Apostolic Christian Home for the Handicapp	100%	Apostolic Christian Timber Ridge	Morton	Community	Morton	Residential Service
		Oakwood Estate	Morton	Residential Services		for the Disabled

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Office Rent	$ 2,520	Apostolic Christian Timber Ridge	100.00%	$ 2,520	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 2,520			$ 2,520	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Knobloch	Chairman	Director	0.00		0.5			$		1
2	Richard Steffen	Vice Chairman	Director	0.00		0.5					2
3	Dan Schumacher	Sec/ Treasurer	Director	0.00		1					3
4	Jerry Christensen	Director	Director	0.00		0.5					4
5	Ron Hodel	Director	Director	0.00		0.5					5
6	Jerry Kieser	Director	Director	0.00		0.5					6
7	Keith Pflum	Director	Director	0.00	652	0.5		Travel	92	line 24; col.3	7
8	Ed Sauder	Director	Director	0.00		0.5					8
9	Stan Virkler	Director	Director	0.00	461	0.5		Travel	65	line 24; col.3	9
10	Warren Zahner	Director	Director	0.00	1,122	0.5		Travel	159	line 24; col.3	10
11											11
12											12
13								TOTAL	$ 316		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Apostolic Christian Timber Ridge
Street Address: 2125 Veterans Road
City / State / Zip Code: Morton, IL 61550
Phone Number: (309) 266-9781
Fax Number: (309) 266-9468

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34	Office rent	No. of residents	148	148	$ 23,467	$ 0	16	$ 2,520	1
2										2
3	6,10a,17,21	Wages	Direct cost / # of hours	2,394	2,394	46,487	46,487	2,394	46,487	3
4										4
5	22	Fringe Benefits	Direct cost / # of hours	2,394	2,394	10,547	10,547	2,394	10,547	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 80,501	$ 57,034		$ 59,554	25

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$ 0	$ 0			$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$ 0	$ 0			$ 0	14
15	**TOTALS (line 9+line14)**						$ 0	$ 0			$ 0	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Linden Estate # 0039305 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ 0	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6		$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999		8
	2000		9
	2001		10
	2002		11
	2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Linden Estate COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0039305

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) Tax Applicable to

	Tax Index Number	Property Description	Total Tax	Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848 B. General Construction Type: Exterior Brick Veneer Frame Wood Frame Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	16 bed home	87,120	1993	$ 52,959	1
2					2
3	TOTALS	87,120		$ 52,959	3

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1994	$ 244,343	$ 8,145	30	$ 8,145	$	$ 87,334	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	403 -- Mirrors			1988	3,509	21	10	21		3,509	9
10	429 -- Landscaping			1988	9,369	592	10	592		9,369	10
11	435 -- Organizational Costs			1988	16,544	0	15	0		16,544	11
12	436 -- Light Fixtures			1988	41	0	12	0		41	12
13	434 -- Concrete for Water Spillway			1988	3,790	20	10	20		3,790	13
14	401 -- Painting /Dumpster			1988	26,269	14	5	14		26,269	14
15	402 -- Generator Wing			1989	458	18	8	18		458	15
16	598 -- Livingroom carpet			1989	3,764	71	10	71		3,764	16
17	625 -- Bathroom remodel			1994	1,548	30	10	30		1,548	17
18	520 -- Lobby Carpet			1988	621	84	30	84		342	18
19	437 -- Cabinetry/Countertops/Vanities			1988	1,747	546	20	546		1,441	19
20	430 -- Lawn Sprinkler System			1988	1,368	163	30	163		752	20
21	432 -- Lighting & Down Spout Trenches			1988	7,277	266	20	266		6,003	21
22	433 -- Sod for Lawn			1988	7,650	263	25	263		5,049	22
23	431 -- Concrete for Porches			1989	4,287	368	30	368		2,215	23
24	399 -- Shelter			1989	23,166	445	20	445		17,953	24
25	441 -- Heating & Air Conditioning			1989	23,005	1,312	25	1,312		14,263	25
26	428 -- Asphalt			1989	24,890	1,677	25	1,677		15,431	26
27	438 -- Fire Prevention System			1989	36,140	567	25	567		22,406	27
28	398 -- Garage			1991	2,010	1,014	20	1,014		1,357	28
29	440 -- Electrical			1995	709	1,529	40	1,529		169	29
30	439 -- Plumbing			1995	733	1,635	40	1,635		174	30
31	427 -- Sewer System			1995	775	1,111	40	1,111		185	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 444,013	$ 19,889		$ 19,889	$ 0	$ 240,367	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 46,434	$ 5,129	$ 5,129	$ 0	five-fifteen	$ 21,954	71
72	Current Year Purchases	13,914	994	994	0	7	994	72
73	Fully Depreciated Assets	59,975	4,932	4,932	0	10	59,975	73
74					0			74
75	TOTALS	$ 120,323	$ 11,055	$ 11,055	$ 0		$ 82,923	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 617,295	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,944	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,944	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 323,289	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)	0	774		774
4	Clinical Wages (b)	0	1,547		1,547
5	In-House Trainer Wages (c)	0	1,827		1,827
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 4,148	$ 0	$ 4,148
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,148			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	0
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 400	$ 831,974	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	86,166	612,852	3
4	Supply Inventory (priced at 3,289)	3,289	48,435	4
5	Short-Term Investments		4,122,774	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	859	14,128	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Receivables	35	80,807	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 90,749	$ 5,710,969	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	145,687	666,412	13
14	Buildings, at Historical Cost	396,259	3,589,105	14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	102,862	1,814,894	16
17	Accumulated Depreciation (book methods)	(297,921)	(3,376,414)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	11,887	46,122	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(11,887)	(46,122)	20
21	Restricted Funds		3,162,940	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		19,491	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 346,888	$ 5,876,428	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 437,637	$ 11,587,397	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,610	$ 65,644	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,857	382,376	30
31	Accrued Taxes Payable (excluding real estate taxes)		11,623	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	12,080	194,003	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 36,547	$ 653,646	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 36,547	$ 653,646	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 401,090	$ 10,933,751	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 437,637	$ 11,587,397	48

***(See instructions.)**

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 424,751	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 424,751	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	24,846	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) **Donated Capital returned to other facilities**	(48,507)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (23,661)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 401,090	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 617,202	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 617,202	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	3,319	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 3,319	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,128	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,128	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 635,649	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	96,545	31
32	Health Care	268,211	32
33	General Administration	178,419	33
	B. Capital Expense		
34	Ownership	33,464	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	34,164	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 610,803	40
41	**Income before Income Taxes (line 30 minus line 40)****	24,846	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 24,846	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	882	882	19,229	21.80	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,677	2,906	26,111	8.99	15
16	Dishwashers					16
17	Maintenance Workers	913	913	14,370	15.74	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	666	666	16,035	24.08	20
21	Assistant Administrator					21
22	Other Administrative	223	223	5,934	26.61	22
23	Office Manager	219	219	4,050	18.49	23
24	Clerical	944	944	19,402	20.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,850	2,099	32,693	15.58	29
30	Habilitation Aides (DD Homes)	17,967	19,768	200,738	10.15	30
31	Medical Records					31
32	Other Health C: OT/PT	39	39	582	14.92	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	26,380	28,659	$ 339,144 *	$ 11.83	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	24	$ 973	1-3	35
36	Medical Director	flat fee	234	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	flat fee	437	10-3	39
40	Physical Therapy Consultant	12	687	10a-3	40
41	Occupational Therapy Consultant	16	887	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	17	1,164	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	7	549	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	76	$ 4,931		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Helen Schuon	Administrator	0	$ 13,886
Ron Messner	Executive Director	0	2,149
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 16,035

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heinold & Banwart, LTD.	Acctg. & Consulting	$ 3,115
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,115

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,248
Unemployment Compensation Insurance	
FICA Taxes	26,003
Employee Health Insurance	40,698
Employee Meals	12,414
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	81
Employee Promotional	909
Defined Contribution Pension Plan	12,691
Employee Scholarships	600
Benefits for Transferred wages	11,944
TOTAL (agree to Schedule V, line 22, col.8)	$ 112,588

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,000
Advertising: Employee Recruitment	
Health Care Worker Background Check	25
(Indicate # of checks performed 2)	
CARF Accreditation	848
Illinois Dept. of Professional Regulation	50
Dues (Chamber, Employers Assn, IHCA)	826
Subscriptions (journals, news, etc.)	253
	0
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,002

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Board of Directors travel	224
In-State Travel	
Board of Directors travel	93
Seminar Expense	
Less out of state travel	(224)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 93

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $826**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **155** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **34,164**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **12,414** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **4,087**
c. What percent of all travel expense relates to transportation of nurses and patients? **75%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Heinold-Banwart, LTD.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **Report - Consolidated basis only**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Linden Estate
FYE 6/30/2003 **#0033712**
Subschedules

Schedule V - Costs per General Ledger

Lines	Description	Amount
27	Dental costs	3,103
27	Donated Labor	239
27	Miscellaneous	(8)
	Other Expenses	3,334

Schedule V - Reclassifications

Lines	Description	Amount Increase	Amount Decrease
11	Donated labor	239	
27	Donated labor		239
38	Medically necessary transportation	3,319	
14	Medically necessary transportation		2,661
6	Medically necessary transportation		658
13	Nurse aid trainer wages	2,741	
1	Nurse aid trainer wages		9
6	Nurse aid trainer wages		14
10	Nurse aid trainer wages		1,496
10a	Nurse aid trainer wages		60
11	Nurse aid trainer wages		6
12	Nurse aid trainer wages		1,134
15	Nurse aid trainer wages		4
17	Nurse aid trainer wages		18
39	Dental costs	3,103	
27	Dental costs		3,103
		9,402	9,402

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 31 visits	$ 3,103

Schedule VI B - Non-paid workers

Lines	Description	Amount
31	Donated Labor	$ 239
Department	Time in Hours	Time in Dollars
Activities	43.50	239
Laundry	-	
Maintenance	-	
Office	-	-
PT/OT	-	
Social Service Programs	-	
Totals	43.50	$ 239

Schedule VII - Compensation Received From Other Nursing Hom

Stan Virkler - $461 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate
Keith Pflum - $652 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate
Warren Zahner - $1122 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets

Investment in Related Entities	-

Sch. XVII - Income Statement, Line 28; Other Revenue

Donated Vehicle	13,914
	13,914

Sch. XVII - Income Statement, Line 41 - Income Before Taxes

Income before taxes per cost report	24,846
Income from related parties	628,700
Estimated excess for year, Form 990, p.1, line 18	653,546

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation

Salaries, Sch V, Line 45, Col 1	339,144
Add Prior Year PTO Accrual at 06/30/03	12,743
Less Current Year PTO Accrual at 06/30/04	(11,790)
Cash basis salaries	340,097
FICA rate	7.650%
Calculated FICA	26,017
FICA per Sch XIX	26,003
Unknown variance	14

Sch. XX - General Information

12. Nurse Aide Trainer Wages:

Administrator	18
Therapy / PT / OT	60
Activities Director	6
Day Program	4
Head Cook	9
Maintenance	14
Nursing	1,496
Soc. Serv. / QMRP	1,134
	2,741

14. A portion of office space is allocated to related entities based on number of beds.

16. Out of State Travel

Board of Directors

Stan Virkler	65
Warren Zahner	159
	224

Cell: A5
Comment: Done
2004

Cell: F5
Comment: Done
2004

Cell: J5
Comment: Done
2004

Cell: F7
Comment: Done
2004

Cell: F18
Comment: Done
2004

Cell: F32
Comment: Done
2004

Cell: J34
Comment: Done
2004

Cell: A37
Comment: Done
2004

LINDEN ESTATE #0039305

ATTACHMENT TO SCHEDUDLE VII A

Related Organizations:

Apostolic Christian Timber Ridge, Morton, IL #0016220
Oakwood Estate, Morton, IL #0033712

Board of Directors for Apostolic Christian Timber Ridge, Oakwood Estate, and Linden Estate:

John Knobloch, Chairman
Richard Steffen, Vice Chairman
Dan Schumacher, Secretary/ Treasurer
Jerry Christensen, Director
Ron Hodel, Director (term began 03/31/2004)
Jerry Kieser, Director
Keith Pflum, Director
Ed Sauder, Director (term ended 03/31/2004)
Stan Virkler, Director
Warren Zahner, Director

Note: The Board members are identical for all three organizations.

No members of the Board of Directors provided direct services to any of the nursing homes. No Board members have ownership in an entity that conducted business transactions with any of these nursing homes.

LINDEN ESTATE #0039305

	Pioneer Park	PARC	Van-Pioneer Park	Cost per Trip	Cost per Day		Total Cost per Year	Less Depreciation	Reallocation Amounts	Sch. V Col. 7 Line #	Schedule for Reallocation
Trips per Day	2	2	1								
Miles per trip	40	40	40								
Gas/Depreciation Price per Mile	$0.65	$0.75	$0.35								
Hours per trip	1 1/4	1 1/4	1 1/4								
Attendant Wages	$7.75	$7.75									
Driver Wages	$12.00	$12.00	$10.00								
Gas & Depreciation	$ 26.00	$ 30.00	$ 14.00	$ 70.00	**$ 126.00**	53.11%	**36,006.76**	(21,275.00)	**14,732.00**	14	**Sch. VI Ln. 29**
Depreciation					**$ -**			21,275.00	**21,275.00**	Sch XI (F)	**Sch. VI Ln. 29**
Driver Wages	$ 15.00	$ 15.00	$ 12.50	$ 42.50	**$ 72.50**	30.56%	**20,718.18**		**20,718.00**	6	**Sch. VI Ln. 1**
Attendant Wages	$ 9.69	$ 9.69	$ -	$ 19.38	**$ 38.76**	16.34%	**11,076.37**		**11,076.00**	10	**Sch. VI Ln. 29**
Total	$ 50.69	$ 54.69	$ 26.50	$ 131.88	**$ 237.26**		**67,801.30**		**67,801.00**		

AIDE CLASSES **LINDEN ESTATE #0039305** **From: 07/01/2003 to 06/30/2004**

CLASS DATE		TR					OE					LE					CILA				
		# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages	# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages	# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages	# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages
completed	**38**	26	520	$ 4,420.00	*1040*	$ 8,840.00	1	80	$ 680.00	160	$ 1,360.00	1	15	$127.50	30	$ 255.00	10	252	$2,142.00	504	$4,284.00
still enrolled, not complete	**30**	23	*539*	$ 4,581.50	*1078*	$ 9,163.00	2	*0*	$ -	*0*	$ -	3	76	$646.00	*152*	$1,292.00	2	42	$ 357.00	*84*	$ 714.00
dropouts	**22**	21	*228*	$ 1,938.00	*456*	$ 3,876.00	0	*0*	$ -	*0*	$ -	0	0	$ -	*0*	$ -	1	16	$ 136.00	*32*	$ 272.00
				$ -	*0*	$ -			$ -	*0*	$ -			$ -	*0*	$ -			$ -	*0*	$ -
				$ -	*0*	$ -			$ -	*0*	$ -			$ -	*0*	$ -			$ -	*0*	$ -
				$ -	*0*	$ -			$ -	*0*	$ -			$ -	*0*	$ -			$ -	*0*	$ -
Total	1768	70	1287	$ 10,939.50	2574	$ 21,879.00	3	80	$ 680.00	160	$ 1,360.00	4	91	$773.50	182	$1,547.00	13	310	$2,635.00	620	$5,270.00

TRAINER WAGES	Classification	Hours	Hourly Rate	Wages	Hours/Class	# of Classes	WAGES TR	WAGES OE	WAGES LE	WAGES CILA	Hours TR	Hours OE	Hours LE	Hours CILA
QMRP - Don Bowers	12q	*36*	$ 16.05	$ 577.80	6	6	420.60	26.14	29.74	101.31	26.21	1.63	1.85	6.31
Dietary Manager - Lori Brittain	1	*12*	$ 15.03	$ 180.36	2	6	131.29	8.16	9.28	31.62	8.74	0.54	0.62	2.10
ADON - Marcella Chapman	10	*20*	$ 21.50	$ 430.00	4	5	313.01	19.46	22.13	75.40	14.56	0.90	1.03	3.51
DON - Maurine Collett	10	*15*	$ 29.83	$ 447.45	3	5	325.72	20.25	23.03	78.46	10.92	0.68	0.77	2.63
QMRP - Theresa Duhs	12q	*20*	$ 16.26	$ 325.20	4	5	236.73	14.71	16.74	57.02	14.56	0.90	1.03	3.51
RN Instructor - Inge Flinn	10	*1560*	$ 18.00	$ 28,080.00			20,440.59	1,270.59	1,445.29	4,923.53	1,135.59	70.59	80.29	273.53
Maintenance - Gary Folkerts	6	*12*	$ 22.23	$ 266.76	2	6	194.19	12.07	13.73	46.77	8.74	0.54	0.62	2.10
Activities - Mary Beth Garza	11	*1*	$ 12.41	$ 12.41	1	1	9.03	0.56	0.64	2.18	0.73	0.05	0.05	0.18
Aide - Thad Gehret	10a	*5*	$ 10.98	$ 54.90	5	1	39.96	2.48	2.83	9.63	3.64	0.23	0.26	0.88
RSD - Jenny Grow	12r	*2*	$ 15.27	$ 30.54	1	2	22.23	1.38	1.57	5.35	1.46	0.09	0.10	0.35
Day Program - Vickie Hale	15	*4*	$ 17.39	$ 69.56	1	4	50.64	3.15	3.58	12.20	2.91	0.18	0.21	0.70
Aide - Crystal Myers Johnson	10a	*6*	$ 9.42	$ 56.52	3	2	41.14	2.56	2.91	9.91	4.37	0.27	0.31	1.05
Aide - Shelly McLaughlin	10a	*4*	$ 10.55	$ 42.20	2	2	30.72	1.91	2.17	7.40	2.91	0.18	0.21	0.70
Aide - Shelly McLaughlin	10a	*10*	$ 10.55	$ 105.50	5	2	76.80	4.77	5.43	18.50	7.28	0.45	0.51	1.75
OT/PT - Kami Miller	10ot	*20*	$ 16.71	$ 334.20	4	5	243.28	15.12	17.20	58.60	14.56	0.90	1.03	3.51
RSD - Evie Mogler	12r	*2*	$ 19.45	$ 38.90	1	2	28.32	1.76	2.00	6.82	1.46	0.09	0.10	0.35
RSD - Randy Mogler	12r	*40*	$ 22.22	$ 888.80	8	5	646.99	40.22	45.75	155.84	29.12	1.81	2.06	7.01
RSD - Rob Mooney	12r	*2*	$ 15.35	$ 30.70	1	2	22.35	1.39	1.58	5.38	1.46	0.09	0.10	0.35
Activity Director - Kevin Pilger	11	*6*	$ 18.28	$ 109.68	1	6	79.84	4.96	5.65	19.23	4.37	0.27	0.31	1.05
DON - Anna Liza Raboza	10	*3*	$ 29.90	$ 89.70	3	1	65.30	4.06	4.62	15.73	2.18	0.14	0.15	0.53
Speech - Alisa Robb	10s	*24*	$ 14.70	$ 352.80	4	6	256.82	15.96	18.16	61.86	17.47	1.09	1.24	4.21
Speech - Alisa Robb	10s	*15*	$ 14.70	$ 220.50	3	5	160.51	9.98	11.35	38.66	10.92	0.68	0.77	2.63
Administrator - Helen Schuon	17	*15*	$ 22.74	$ 341.10	3	5	248.30	15.43	17.56	59.81	10.92	0.68	0.77	2.63
Day Program - Vikki Steele	15	*1*	$ 10.23	$ 10.23	1	1	7.45	0.46	0.53	1.79	0.73	0.05	0.05	0.18
OJT Instructor - Lynn Wuthrich	12ojt	*1560*	$ 12.92	$ 20,155.20			14,671.80	912.00	1,037.40	3,534.00	1,135.59	70.59	80.29	273.53
							-	-	-	-	-	-	-	-
							38,763.60	2,409.55	2,740.86	9,337.00	2,471.36	153.62	174.74	595.28
Total trainer wages		*3395*		$ 53,251.01										

	TR	OE	LE	CILA
Drop-Outs				
Number from this Facility	21	0	0	1
Clinical Wages	$ 3,876.00	$ -	$ -	$ 272.00
Classroom Wages	$ 1,938.00	$ -	$ -	$ 136.00
In-House Trainer Wages	$ 2,289.00	$ -	$ -	$ 161.00
Completed				
Number from this Facility	49	3	4	12
Clinical Wages	$ 9,002.00	$ 680.00	$ 774.00	$2,499.00
Classroom Wages	$ 18,003.00	$ 160.00	$ 1,547.00	$4,998.00
In-House Trainer Wages	$ 21,264.00	$ 459.00	$ 1,827.00	$5,903.00

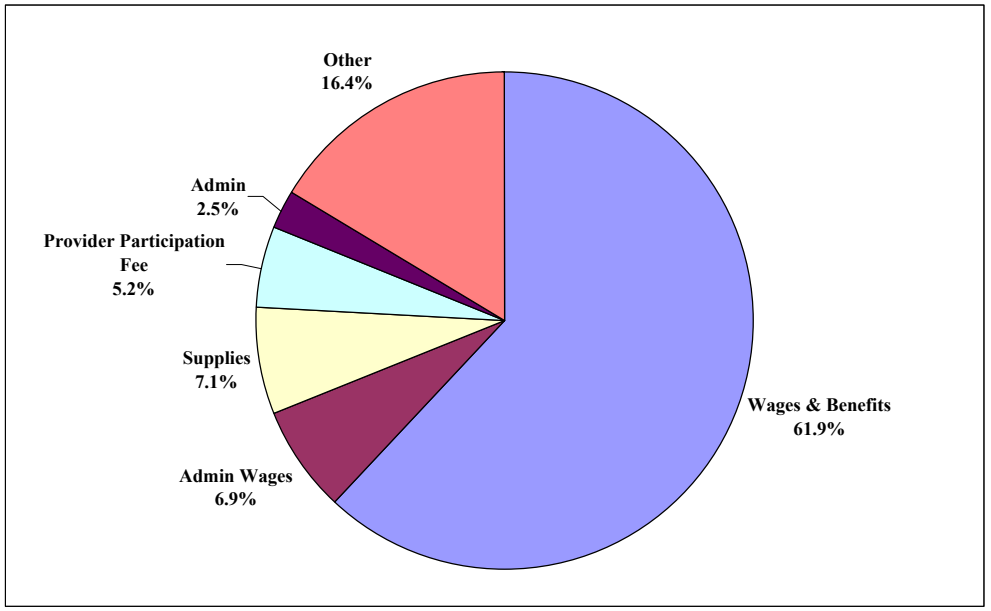
Schedule V

		Line	TR Change	OE Change	LE Change	CILA Change
Dietary	1	1	(131.00)	(8.00)	(9.00)	(32.00)
Maintenance	6	6	(194.00)	(12.00)	(14.00)	(47.00)
Nursing	10	10	(21,145.00)	(1,314.00)	(1,495.00)	(5,093.00)
Therapy	10a	10a	(189.00)	(12.00)	(13.00)	(45.00)
OT/PT	10ot	10a	(243.00)	(15.00)	(17.00)	(59.00)
Activities	11	11	(89.00)	(6.00)	(6.00)	(21.00)
RSD	12r	12	(720.00)	(45.00)	(51.00)	(173.00)
QMRP's	12q	12	(657.00)	(41.00)	(46.00)	(158.00)
Training Wage	13	13	38,764.00	2,410.00	2,741.00	9,337.00
Day Program	15	15	(58.00)	(4.00)	(4.00)	(14.00)
Administrator	17	17	(248.00)	(15.00)	(18.00)	(60.00)
OJT	12ojt	12	(14,672.00)	(912.00)	(1,037.00)	(3,534.00)
Speech	10s	10a	(417.00)	(26.00)	(30.00)	(101.00)
Adjustment		10	(1.00)	-	(1.00)	-
			-	-	-	-

Linden Estate -- 0039305

		Salary/Wage	Supplies	Other	Total	Reclass-ification	Total	Cost / Day Resident Days 5,379	Adjust-ments	Adjusted Total	Cost / Day Resident Days 5,379	% of Total Costs	% of Daily Rate	Staff Hours/ Day
	A. General Services													
1	Dietary	26,111	2,535	1,329	29,975	(14)	29,961	$5.57	-	29,961	$5.57	4.9%	5.2%	4.10
2	Food Purchase	-	26,241	-	26,241	-	26,241	$4.88	-	26,241	$4.88	4.3%	4.6%	
3	Housekeeping	-	1,944	-	1,944	-	1,944	$0.36	-	1,944	$0.36	0.3%	0.3%	1.37
4	Laundry	-	926	-	926	-	926	$0.17	-	926	$0.17	0.2%	0.2%	1.94
5	Heat and Other Utilities	-	-	17,496	17,496	-	17,496	$3.25	-	17,496	$3.25	2.9%	3.1%	
6	Maintenance	14,370	1,814	3,779	19,963	(402)	19,561	$3.64	(388)	19,173	$3.56	3.2%	3.3%	0.91
7	Other (specify):*	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
8	**TOTAL General Services**	**40,481**	**33,460**	**22,604**	**96,545**	**(416)**	**96,129**	**$17.87**	**(388)**	**95,741**	**$17.80**	**15.8%**	**16.7%**	**8.32**
	B. Health Care and Programs													
9	Medical Director	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
10	Nursing and Medical Records	19,229	5,698	746	25,673	(1,496)	24,177	$4.49	-	24,177	$4.49	4.0%	4.2%	7.27
10a	Therapy	201,320	-	1,574	202,894	(60)	202,834	$37.71	-	202,834	$37.71	33.4%	35.4%	22.86
11	Activities	-	1,433	-	1,433	233	1,666	$0.31	-	1,666	$0.31	0.3%	0.3%	3.98
12	Social Services	32,693	6	2,513	35,212	(1,134)	34,078	$6.34	-	34,078	$6.34	5.6%	5.9%	2.13
13	Nurse Aide Training	-	68	-	68	2,741	2,809	$0.52	-	2,809	$0.52	0.5%	0.5%	0.34
14	Program Transportation	-	2,931	-	2,931	(2,931)	-	$0.00	-	-	$0.00	0.0%	0.0%	
15	Other (specify):*	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
16	**TOTAL Health Care and Programs**	**253,242**	**10,136**	**4,833**	**268,211**	**(2,647)**	**265,564**	**$49.37**	**-**	**265,564**	**$49.37**	**43.8%**	**46.3%**	**36.58**
	C. General Administration													
17	Administrative	16,035	-	-	16,035	(18)	16,017	$2.98	-	16,017	$2.98	2.6%	2.8%	0.32
18	Directors Fees	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
19	Professional Services	-	-	3,115	3,115	-	3,115	$0.58	-	3,115	$0.58	0.5%	0.5%	
20	Dues, Fees, Subscriptions & Promotions	-	-	3,145	3,145	-	3,145	$0.58	(143)	3,002	$0.56	0.5%	0.5%	
21	Clerical & General Office Expenses	29,386	2,686	-	32,072	-	32,072	$5.96	-	32,072	$5.96	5.3%	5.6%	0.81
22	Employee Benefits & Payroll Taxes	-	-	112,588	112,588	-	112,588	$20.93	-	112,588	$20.93	18.6%	19.6%	
23	Inservice Training & Education	-	-	503	503	-	503	$0.09	-	503	$0.09	0.1%	0.1%	
24	Travel and Seminar	-	-	317	317	-	317	$0.06	(224)	93	$0.02	0.0%	0.0%	
25	Other Admin. Staff Transportation	-	-	230	230	-	230	$0.04	-	230	$0.04	0.0%	0.0%	
26	Insurance-Prop.Liab.Malpractice	-	-	7,080	7,080	-	7,080	$1.32	-	7,080	$1.32	1.2%	1.2%	
27	Other (specify):*	-	-	3,334	3,334	(3,342)	(8)	($0.00)	-	(8)	($0.00)	0.0%	0.0%	
28	**TOTAL General Administration**	**45,421**	**2,686**	**130,312**	**178,419**	**(3,360)**	**175,059**	**$32.54**	**(367)**	**174,692**	**$32.48**	**28.8%**	**30.5%**	**1.13**
	TOTAL Operating Expense	**339,144**	**46,282**	**157,749**	**543,175**	**(6,423)**	**536,752**	**$99.79**	**(755)**	**535,997**	**$99.65**	**88.3%**	**93.4%**	**46.03**
	D. Ownership													
30	Depreciation	-	-	30,944	30,944	-	30,944	$5.75	-	30,944	$5.75	5.1%	5.4%	
31	Amortization of Pre-Op. & Org.	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
32	Interest	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
33	Real Estate Taxes	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
34	Rent-Facility & Grounds	-	-	2,520	2,520	-	2,520	$0.47	-	2,520	$0.47	0.4%	0.4%	
35	Rent-Equipment & Vehicles	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
36	Other (specify):*	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
37	**TOTAL Ownership**	**-**	**-**	**33,464**	**33,464**	**-**	**33,464**	**$6.22**	**-**	**33,464**	**$6.22**	**5.5%**	**5.8%**	**-**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	-	-	-	-	3,319	3,319	$0.62	(3,319)	-	$0.00	0.0%	0.0%	
39	Ancillary Service Centers	-	-	-	-	3,103	3,103	$0.58	-	3,103	$0.58	0.5%	0.5%	
40	Barber and Beauty Shops	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
41	Coffee and Gift Shops	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
42	Provider Participation Fee	-	-	34,164	34,164	-	34,164	$6.35	-	34,164	$6.35	5.6%	6.0%	
43	Other (specify):*	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
44	**TOTAL Special Cost Centers**	**-**	**-**	**34,164**	**34,164**	**6,422**	**40,586**	**$7.55**	**(3,319)**	**37,267**	**$6.93**	**6.1%**	**6.5%**	**-**
45	**GRAND TOTAL**	**339,144**	**46,282**	**225,377**	**610,803**	**(1)**	**610,802**	**$113.55**	**(4,074)**	**606,728**	**$112.80**	**100.0%**	**105.8%**	**46.03**
	Current Reimbursement Rate							**$106.64**			**$106.64**	**94.5%**	**100.0%**	

Gain/(Loss) Per Resident / Day					**(6.91)**		**(6.16)**	**-5.5%** **-5.8%**
					-6.5%		-5.8%	
% of Costs Per Area	**73.96%**	**7.58%**	**18.47%**	**100.00%**				



Ending Balance	Rounded Balance	Facility -Report - Col - Row	
	Oakwood Estate		
	1	2	3
1	39,506.00	1,946.00	973.00
2	-	29,192.00	-
3	-	1,617.00	-
4	-	1,047.00	-
5	-	-	16,525.00
6	14,022.00	1,601.00	3,118.00
7	-	-	-
8	-	-	-
9	-	-	-
10	20,693.00	5,581.00	732.00
10a	213,454.00	-	1,574.00
11	-	1,386.00	-
12	41,027.00	194.00	2,788.00
13	-	68.00	-
14	-	3,429.00	-
15	-	10.00	-
16	-	-	-
17	15,230.00	-	-
18	-	-	-
19	-	-	3,115.00
20	-	-	2,549.00
21	30,123.00	2,964.00	-
22	-	-	121,548.00
23	-	-	438.00
24	-	-	317.00
25	-	-	230.00
26	-	-	7,080.00
27	-	-	4,005.00
28	-	-	-
29	-	-	-
30	-	-	21,286.00
31	-	-	-
32	-	-	-
33	-	-	-
34	-	-	2,520.00
35	-	-	-
36	-	-	-
37	-	-	-
38	-	-	-
39	-	-	-

Ending Balance	Rounded Balance	Facility -Report - Col - Row	
40	-	-	-
41	-	-	-
42	-	-	34,164.00
43	-	-	-
	374,055.00	49,035.00	222,962.00
	34,911		374,055.00
			49,035.00
			222,962.00
		35,249	646,052.00
			$0.00